		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036343

Facility Name: Hallmark House Nursing Center

Address: 2501 Allentown Road (Number) Pekin (City) 61554 (Zip Code)

County: Tazewell

Telephone Number: (309) 347-3121 **Fax #** (309) 347-1547

IDPA ID Number: 371262983001

Date of Initial License for Current Owners: 5/1/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Scott C. Jolley **Telephone Number:** (801) 274-8866

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Scott C. Jolley, CPA
(Firm Name & Address) Pinnacle Healthcare Consulting, 4625 S. 2300 E., Suite 104, Salt Lake City, UT 84117
(Telephone) (801) 274-8866 Fax # (801) 274-8861

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)	71	25,915	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	71	25,915	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,583	15,129	1,267	20,979	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,583	15,129	1,267	20,979	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.95%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 5/1/90

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 12/20/80 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 18 and days of care provided 1,267

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	161,477	13,160	8,482	183,119	2,282	185,401		185,401			1
2	Food Purchase		118,739		118,739		118,739	(1,855)	116,884			2
3	Housekeeping	77,649	14,687		92,336	1,503	93,839		93,839			3
4	Laundry	35,254	8,464		43,718	831	44,549		44,549			4
5	Heat and Other Utilities			61,240	61,240		61,240		61,240			5
6	Maintenance	61,604	49,520	1,123	112,247	521	112,768		112,768			6
7	Other (specify):*											7
8	**TOTAL General Services**	335,984	204,570	70,845	611,399	5,137	616,536	(1,855)	614,681			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	877,546	62,750	73,280	1,013,576	(1,848)	1,011,728		1,011,728			10
10a	Therapy		152	73,689	73,841		73,841		73,841			10a
11	Activities	51,167	4,823	3,381	59,371		59,371		59,371			11
12	Social Services	29,037	39	3,477	32,553		32,553		32,553			12
13	Nurse Aide Training			1,337	1,337	6,405	7,742		7,742			13
14	Program Transportation			27	27		27		27			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	957,750	67,764	158,791	1,184,305	4,557	1,188,862		1,188,862			16
	C. General Administration											
17	Administrative	145,666		210,255	355,921		355,921		355,921			17
18	Directors Fees											18
19	Professional Services			17,519	17,519		17,519	19	17,538			19
20	Dues, Fees, Subscriptions & Promotions			21,247	21,247		21,247	(8,612)	12,635			20
21	Clerical & General Office Expenses	7,044	8,961	46,202	62,207	(6,080)	56,127		56,127			21
22	Employee Benefits & Payroll Taxes			257,706	257,706		257,706		257,706			22
23	Inservice Training & Education					1,782	1,782		1,782			23
24	Travel and Seminar			11,176	11,176	(5,396)	5,780		5,780			24
25	Other Admin. Staff Transportation			8,690	8,690		8,690		8,690			25
26	Insurance-Prop.Liab.Malpractice			51,468	51,468		51,468		51,468			26
27	Other (specify):*											27
28	**TOTAL General Administration**	152,710	8,961	624,263	785,934	(9,694)	776,240	(8,593)	767,647			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,446,444	281,295	853,899	2,581,638		2,581,638	(10,448)	2,571,190			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Hallmark House Nursing Center #0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			97,054	97,054		97,054	12,445	109,499			30
31	Amortization of Pre-Op. & Org.							137	137			31
32	Interest			17,552	17,552		17,552	(2,253)	15,299			32
33	Real Estate Taxes			36,823	36,823		36,823		36,823			33
34	Rent-Facility & Grounds			227,749	227,749		227,749		227,749			34
35	Rent-Equipment & Vehicles			1,277	1,277		1,277		1,277			35
36	Other (specify):* Loan Fee Amort.			128	128		128		128			36
37	TOTAL Ownership			380,583	380,583		380,583	10,329	390,912			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			42,422	42,422		42,422		42,422			39
40	Barber and Beauty Shops			1,048	1,048		1,048		1,048			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,075	29,075		29,075		29,075			42
43	Other (specify):* X-Ray & Lab			3,699	3,699		3,699		3,699			43
44	TOTAL Special Cost Centers			76,244	76,244		76,244		76,244			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,446,444	281,295	1,310,726	3,038,465		3,038,465	(119)	3,038,346			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,855)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,300	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(3,099)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(344)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,268)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,266)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,147		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,147		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (119)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Hallmark House Nursing Center

ID# 0036343

Report Period Beginning: 1/1/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,855)	0	0	0	0	0	0	0	0	0	0	(1,855)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,855)	0	0	0	0	0	0	0	0	0	0	(1,855)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19	0	0	0	0	0	0	0	0	0	19	19
20	Fees, Subscriptions & Promotions	(8,612)	0	0	0	0	0	0	0	0	0	0	(8,612)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(8,612)	19	0	0	0	0	0	0	0	0	0	(8,593)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,467)	19	0	0	0	0	0	0	0	0	0	(10,448)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hallmark House Nursing Center # 0036343 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	11,300	1,145	0	0	0	0	0	0	0	0	0	12,445	30
31	Amortization of Pre-Op. & Org.	0	137	0	0	0	0	0	0	0	0	0	137	31
32	Interest	(3,099)	846	0	0	0	0	0	0	0	0	0	(2,253)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	8,201	2,128	0	0	0	0	0	0	0	0	0	10,329	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,266)	2,147	0	0	0	0	0	0	0	0	0	(119)	45

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mr. Lloyd Miller	100			Advance Capital Management	Vallejo, CA	Management Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$	Advance Capital Management	100.00%	$ 19	$ 19	1
2	V	31	Amortization		Advance Capital Management	100.00%	137	137	2
3	V	32	Interest Expense		Advance Capital Management	100.00%	846	846	3
4	V	30	Depreciation		Advance Capital Management	100.00%	1,145	1,145	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 2,147	$ * 2,147	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mr. Lloyd Miller	President	Administrative	100.00	0	40	100.00	Mgt. Fee	$ 210,255	L.17 C.1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 210,255		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Security Saving Bank		x	Mortgage	$5,292.00	8/17/96	$ 555,252	$ 357,561	8/17/16	0.0709	$ 26,777	1
2	Security Saving Bank		x	Hallway Remodeling	$2,095.00	11/1/98	98,711	18,192	11/1/03	0.0940	2,861	2
3	Security Saving Bank		x	Admin. Office Addition	$3,034.00	2/26/00	241,200	193,053	3/1/10	0.0911	18,484	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$10,421.00		$ 895,163	$ 568,806			$ 48,122	9
	B. Non-Facility Related*											
10	Interest Income Offset										(3,099)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,099)	14
15	TOTALS (line 9+line14)						$ 895,163	$ 568,806			$ 45,023	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Hallmark House Nursing Center **#** 0036343 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	31,560	2
3. Under or (over) accrual (line 2 minus line 1).	$	31,560	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	5,263	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	36,823	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	24,371	8
	1998	24,934	9
	1999	25,880	10
	2000	26,256	11
	2001	31,560	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hallmark House Nursing Center COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0036343

CONTACT PERSON REGARDING THIS REPORT Scott C. Jolley

TELEPHONE (801) 274-8866 FAX #: (801) 274-8861

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-10-01-407-018	5.96 acres in Pekin township	$ 31,560.00	$ 31,560.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,560.00	$ 31,560.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,782 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	292,455	1980	$ 57,000	1
2					2
3	TOTALS	292,455		$ 57,000	3

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	71		1980	1976	$ 510,430	$	40	$ 12,761	$ 12,761	$ 216,934	4
5											5
6	Adjustments				290,586		40	7,266	7,266	123,510	6
7											7
8											8
	Improvement Type**										
9	Improvements			1977	41,421		40	1,035	1,035	17,601	9
10	Improvements			1978	6,473		40	162	162	2,752	10
11	Improvements			1981	10,987		40	275	275	4,671	11
12	Improvements			1982	12,368		40	309	309	5,256	12
13	Improvements			1983	7,662		40	191	191	3,252	13
14	Improvements			1984	2,343		40	58	58	990	14
15	Improvements			1986	5,730		40	143	143	2,434	15
16	Improvements			1986	11,874		35	339	339	5,452	16
17	Improvements			1987	7,275		20	364	364	5,591	17
18	Improvements			1988	42,911		20	2,146	2,146	30,565	18
19	Doors			1989	4,250		20	213	213	2,469	19
20	Hot Water System			1989	11,137		20	557	557	6,961	20
21	Air Conditioning System			1990	46,103	2,665	31.5	1,464	(1,201)	17,568	21
22	Bathroom Floors			1991	578	39	25	23	(16)	265	22
23	Privacy Curtains			1991	5,472	113	15	365	252	4,197	23
24	Wiring Improvements			1991	1,062	71	20	53	(18)	605	24
25	Plumbing Improvements			1991	2,024	135	25	81	(54)	918	25
26	Plumbing Improvements			1991	2,000	133	25	80	(53)	900	26
27	Hot Water System			1993	9,074		10	907	907	9,070	27
28	Water Softening			1993	2,101		10	210	210	2,100	28
29	Alarm System			1993	7,927		15	528	528	5,280	29
30	Boiler			1994	14,417		20	721	721	6,128	30
31	Windows			1994	27,592	707	15	1,839	1,132	15,632	31
32	Ceiling			1994	3,365	86	15	224	138	1,904	32
33	Boiler			1995	4,000		20	200	200	1,500	33
34	Fiberglass Insulation			1995	1,900	49	15	127	78	952	34
35	Thermostats			1995	2,068	53	10	207	154	1,552	35
36	Security Lighting			1995	521	13	15	35	22	262	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tile Replacement	1995	$ 1,192	$ 31	20	$ 60	$ 29	$ 450	37
38	Roof	1995	100,406	2,318	25	4,016	1,698	30,120	38
39	Draperies	1996	11,000	982	7	1,570	588	10,205	39
40	Parking Lot Lights	1996	1,600	41	39	41		267	40
41	Office Window	1996	2,358	60	39	60		390	41
42	Boiler	1996	10,895		39	279	279	1,814	42
43	Landscaping (tree)	1996	1,057	62	15	70	8	455	43
44	Telephone System	1997	3,531	91	5	235	144	1,293	44
45	Nursing Station Improvements	1997	8,398	215	20	420	205	2,310	45
46	Doors	1997	1,220	31	15	81	50	446	46
47	Hot Water System	1997	22,703	582	20	1,514	932	8,138	47
48	Carpet	1997	7,345	18	7	1,049	1,031	5,770	48
49	Windows	1998	5,120	131	15	341	210	1,535	49
50	Hallway Remodeling	1998	113,069	2,899	20	5,653	2,754	25,439	50
51	Doors - Folding	1999	4,656	411	15	310	(101)	1,085	51
52	Shed	1999	3,825	98	20	191	93	764	52
53	Carpet	1999	5,557	694	7	794	100	2,779	53
54	Handicap Bathrooms - Two	1999	11,663	299	20	784	485	2,744	54
55	Carpet	1999	5,486	685	7	583	(102)	2,332	55
56	Administration Offices New Additions	2000	50,939	1,306	20	2,547	1,241	7,641	56
57	Administration Offices New Additions	2000	169,375	4,343	20	4,234	(109)	17,796	57
58	Slarm System	2000	18,619	1,592	15	621	(971)	1,863	58
59	Architect fee on Administrative Offices	2000	2,100	180	20	53	(127)	159	59
60	Sidewalks for new addition	2000	5,070	433	15	169	(264)	507	60
61	Telephone System	2000	13,018	2,281	10	651	(1,630)	1,953	61
62	Air Conditioner	2001	2,939	75	39	75		150	62
63	Spa	2001	18,559	4,157	15	1,237	(2,920)	2,474	63
64	Air Conditioner	2002	12,058	3,698	39	309	(3,389)	309	64
65	Remodel Bathroom	2002	2,237	895	7	320	(575)	320	65
66	120 Gallon Storage Tanks - Two	2002	7,880	3,152	7	1,126	(2,026)	1,126	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,719,526	$ 35,824		$ 62,276	$ 26,452	$ 629,905	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 287,463	$ 23,692	$ 41,066	$ 17,374	3-10 yrs	$ 238,672	71
72	Current Year Purchases	58,503	37,539	6,158	(31,381)	5-39 yrs	6,158	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 345,966	$ 61,231	$ 47,224	$ (14,007)		$ 244,830	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1996 Ford Wagon E350	1996	$ 35,576	$	$	$	5	$ 35,576	76
77										77
78										78
79										79
80	TOTALS			$ 35,576	$	$	$		$ 35,576	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,158,068	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 97,055	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 109,500	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,445	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 910,311	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [x] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 1,277 Description: Weed mower $115; Helium tank & santa suit $154.38; Dish machine $899.40; Meter $108
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 30

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 16

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		376		376
3	Classroom Wages (a)		858		858
4	Clinical Wages (b)		462		462
5	In-House Trainer Wages (c)		5,696		5,696
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		350		350
9	TOTALS	$	$ 7,742	$	$ 7,742
10	SUM OF line 9, col. 1 and 2 (e)	$ 7,742			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L. 10a C. 3	hrs	$	71	$ 6,503	$	71	$ 6,503	1
2	Licensed Speech and Language Development Therapist	L. 10a C. 3	hrs		45	3,454		45	3,454	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C. 2 & 3	hrs		1,498	63,733	152	1,498	63,885	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39 C. 3	# of prescrpts				38,457		38,457	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab, X-Ray, Oxygen	L. 39 C. 3 L. 43 C. 3					3,964 3,699		3,699	13
14	TOTAL			$	1,614	$ 73,690	$ 46,272	1,614	$ 115,998	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Hallmark House Nursing Center # 0036343 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 345,308	$ 351,831	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	238,577	436,358	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		1,221,512	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		901	7
8	Accounts Receivable (owners or related parties)	12,000	12,000	8
9	Other(specify): Deposits	750	750	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 596,635	$ 2,023,352	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		267,528	11
12	Long-Term Investments			12
13	Land		553,335	13
14	Buildings, at Historical Cost		3,049,234	14
15	Leasehold Improvements, at Historical Cost	817,954	1,148,831	15
16	Equipment, at Historical Cost	482,098	869,358	16
17	Accumulated Depreciation (book methods)	(707,207)	(2,787,010)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Lease Receivable		160,409	22
23	Other(specify): Unamortized Loan Costs	1,655	3,450	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 594,500	$ 3,265,135	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,191,135	$ 5,288,487	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 186,674	$ 186,714	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,718	114,718	30
31	Accrued Taxes Payable (excluding real estate taxes)	(158)	(158)	31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,700	32,700	32
33	Accrued Interest Payable	849	849	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,580	1,580	35
	Other Current Liabilities(specify):			
36	Accrued Payroll Deductions	(9,129)	(9,129)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 327,234	$ 327,274	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	190,642	1,392,247	39
40	Mortgage Payable		1,297,634	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest Payable		324,433	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 190,642	$ 3,014,314	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 517,876	$ 3,341,588	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 673,259	$ 1,946,899	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,191,135	$ 5,288,487	48

***(See instructions.)**

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,080,638	1
2	Restatements (describe):		2
3	**Fair Market Value Change in Stocks**	(641,421)	3
4	**Cash to Accrual Adjustment**	259,528	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 698,745	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(25,486)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (25,486)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 673,259	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,001,001	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,001,001	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	354	13
14	Non-Patient Meals	1,855	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,209	23
	D. Non-Operating Revenue		
24	Contributions	5,065	24
25	Interest and Other Investment Income***	3,099	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,165	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	396	28
28a	Activity income, Vending machine revenue	1,208	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,604	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,012,979	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	611,399	31
32	Health Care	1,225,848	32
33	General Administration	744,391	33
	B. Capital Expense		
34	Ownership	380,583	34
	C. Ancillary Expense		
35	Special Cost Centers	42,422	35
36	Provider Participation Fee	29,075	36
	D. Other Expenses (specify):		
37	X-Ray & Lab	3,699	37
38	Barber & Beauty	1,048	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,038,465	40
41	**Income before Income Taxes (line 30 minus line 40)****	(25,486)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (25,486)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,092	2,196	$ 49,049	$ 22.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,464	6,076	114,212	18.80	3
4	Licensed Practical Nurses	14,483	15,471	273,660	17.69	4
5	Nurse Aides & Orderlies	35,607	38,159	349,220	9.15	5
6	Nurse Aide Trainees	4,627	4,805	30,252	6.30	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,041	2,202	17,832	8.10	8
9	Activity Director	2,217	2,403	23,267	9.68	9
10	Activity Assistants	4,011	4,178	27,900	6.68	10
11	Social Service Workers	2,057	2,201	29,038	13.19	11
12	Dietician					12
13	Food Service Supervisor	2,985	3,161	42,751	13.52	13
14	Head Cook	6,063	6,639	72,952	10.99	14
15	Cook Helpers/Assistants	3,557	3,865	28,557	7.39	15
16	Dishwashers	5,365	5,782	17,218	2.98	16
17	Maintenance Workers	5,587	5,981	61,604	10.30	17
18	Housekeepers	8,371	9,103	66,259	7.28	18
19	Laundry	4,153	4,359	35,254	8.09	19
20	Administrator	2,049	2,201	71,495	32.48	20
21	Assistant Administrator					21
22	Other Administrative	6,098	6,258	251,798	40.24	22
23	Office Manager	1,994	2,184	32,628	14.94	23
24	Clerical	1,278	1,318	7,044	5.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,892	2,012	24,521	12.19	31
32	Other Health C: Unit Manager	3,431	3,701	30,188	8.16	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,422	134,255	$ 1,656,699 *	$ 12.34	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	99	$ 8,232	L. 1 C. 3	35
36	Medical Director	Monthly	3,600	L. 9 C. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,923	L. 10 C. 3	38
39	Pharmacist Consultant	Monthly	650	L. 10 C. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,770	L. 11 C. 3	44
45	Social Service Consultant	57	3,477	L. 12 C. 3	45
46	Other(specify)				46
47	Special Consultant		10,539	L. 10 C. 3	47
48					48
49	TOTAL (lines 35 - 48)	186	$ 31,191		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	3,160	59,168	L. 10 C. 3	52
53	TOTAL (lines 50 - 52)	3,160	$ 59,168		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lynn Brady	Administrator		$ 71,495
Sharon Doan	Office Manager		3,348
Lori Nufer	Office Manager		29,280
Cheryl Carlson	Compliance		41,543
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 145,666

B. Administrative - Other

Description	Amount
Management Fees	$ 210,255
TOTAL (agree to Schedule V, line 17, col. 3)	$ 210,255
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Benassi & Benassi	Legal	$ 1,042
William J. Judge	Legal	500
Secretary of State	Legal	35
Frank E. Hoffman	Legal	500
County of Tazewell	Legal	20
Pinnacle Healthcare Consulting	Accounting	3,366
Smith & Associates	Accounting	5,900
ADP	Payroll	6,156
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,519

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,228
Unemployment Compensation Insurance	
FICA Taxes	120,310
Employee Health Insurance	77,382
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	1,486
Retirement Plan Fee	223
Employee Physicals	7,120
TOTAL (agree to Schedule V, line 22, col.8)	$ 247,749

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,884
Health Care Worker Background Check	1,082
(Indicate # of checks performed)	
Various dues and subscriptions	7,670
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,636

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	5,780
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,780

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hallmark House Nursing Center # 0036343 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Hallmark House Nursing Center # 0036343 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc. $2,459.31**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,418** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **29,075**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,855**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation. Owner travel from California to facility
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No - Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.